Iowa Department of Human Services

REPORT OF QUALITY CONTROL REVIEW

A.

Name	Case No.		Review No.
IM Worker	County	Area	Program
QC Reviewer	Review Date	Report Date	Challenge Date

B. Quality Control Findings: ☐ Verbal Report to County Office (Date) _____

Negative Study: ☐ Incorrect Reason for Cancellation/Rejection ☐ No Timely Notice Sent

Active Study: ☐ Case Ineligible $ _____ ☐ Eligible with Ineligible Members

☐ Overissuance/Overpayment $ _____ ☐ Underissuance/Underpayment $ _____

☐ Client Participation Overstated $ _____ ☐ Client Participation Understated $ _____

☐ Agency Error ☐ Client Error ☐ Food Stamp Potential IPV ☐ New Information

Comments:

Employees' Manual Reference: _____

NOTE: COUNTY OFFICE RESPONSE SECTION IS ON THE FLIP SIDE OF THIS PAGE.

C. County Office Response: ☐ Corrected to QC Findings ☐ Not Corrected to QC Findings

☐ Claim or Adjustment Completed (Date) _____

☐ Potential IPV Referral (Date) _____ ☐ Potential IPV not Referred

Action Taken:

Information about Error:

1. If information was in the case record and was not used, or not used correctly, please provide any information about how we can help prevent future errors.

2. If the error was client caused, could something have been done to prevent that error, e.g. check income screens, better tracking method, different interview technique, better narrative to alert worker to future questions, better reporting knowledge of client, simpler policy, etc.

3. Given the nature of the error and the time of occurrence state what a worker could do differently to prevent future errors of this type.

4. Other comments about how future errors could be reduced.

Signature of IM Worker _____ Date _____

Signature of Service Area IM Supervisor or Designee _____ Date _____